



# QUALITY IMPROVEMENT



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# HIV/AIDS in 2012

- Third Decade of treating clients with HIV infection
- Transition from a terminal disease to a manageable chronic disease
- In U.S., approx. 1.2 million people living with HIV
- 53,000 new HIV infections annually in the U.S.
- Greatest number of cases are in men who have sex with men (MSM)
- Black people are disproportionately affected – accounting for 48% of HIV/AIDS cases
- Federal recommendation (CDC) – HIV screening recommended for all patients between the ages of 13 and 64

# HHS SEEKS INPUT

- On Streamlining HIV Data Collection to reduce reporting burden for HIV Grantees
  - Duplicate Data Entry – CAREWare not linked to EMRs
  - EMRs unable to collect much of requested data without being customized.

# Quality Improvement Plan

- Specify members of committee
- Frequency of meetings
- Process for data collection/data analysis
- Process to follow-up on problems identified – modify policies/procedures
- Report to consumers and Governing Board (if applicable)
- Formal minutes

# Individual Clinical Guideline

- Work up for all new clients – lab tests, screens, etc.
- Process for following stable clients
- Process for following unstable clients
- Annual exam components

# Risk Stratifying Clients

- Identify the most vulnerable clients
  - CD4 less than 50
  - Viral Load greater than 400,000
  - Clients with mental health issues
  - Clients without social support systems

# Clinical Research

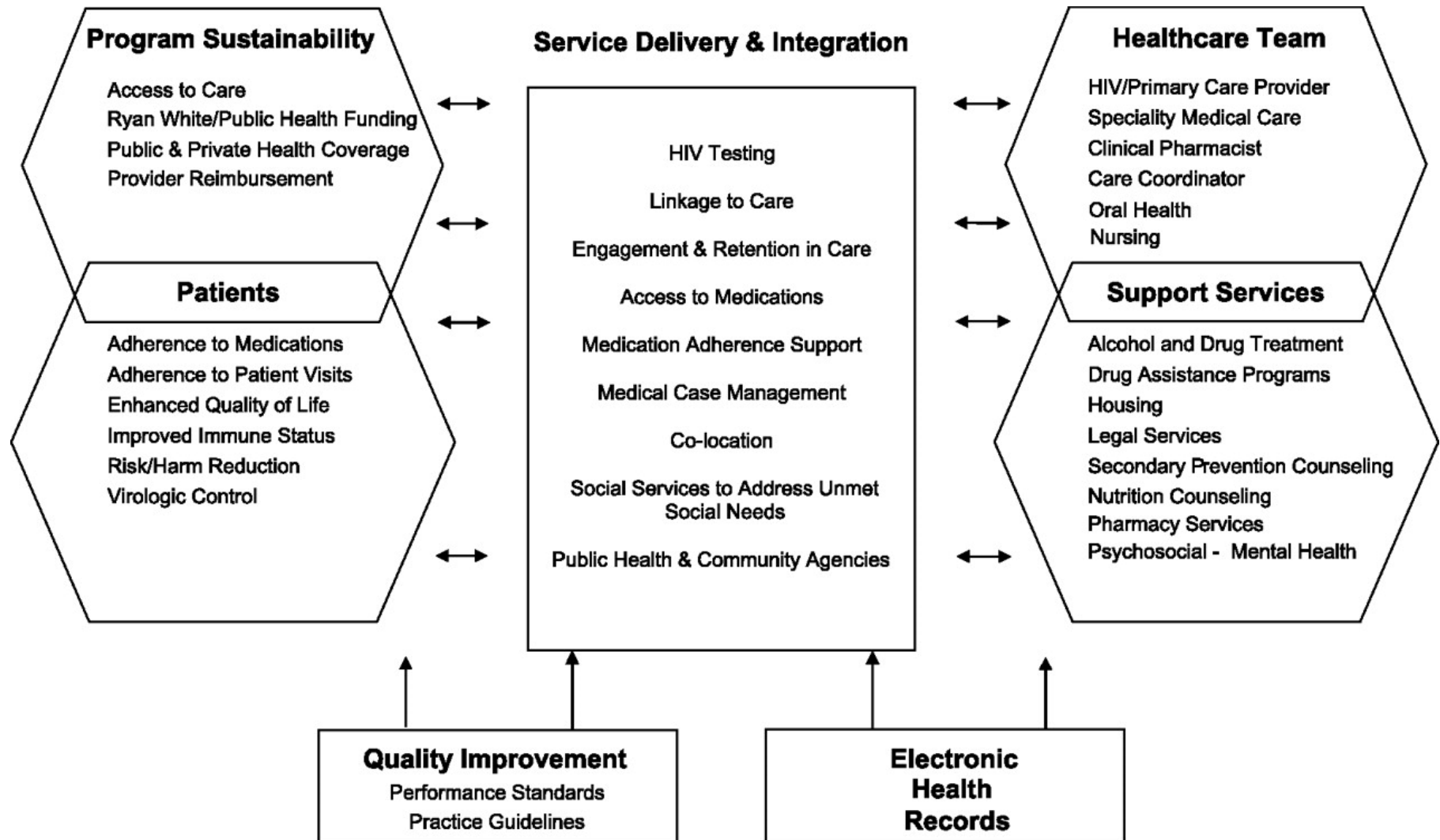
- Written policy for education of clients and family on Clinical Research opportunities
- Bulletin Board
- Sign - “*Ask Me About Clinical Trials*”



# HIV PRIMARY CARE STANDARDS OF CARE



# ESSENTIAL COMPONENTS OF HIV CARE.



# **STANDARDS OF CARE**

Component	Timing
Complete history	Update annually
Risk Assessment – smoking, ETOH, illicit drug use, sexual activity, domestic violence, support systems	Update annually & brief risk assessment at each visit for ongoing appropriate screening & risk reduction counseling
Complete physical exam	Annually
Vision	Annually by eye care specialist, every 6 months with CD4<100
Dental Exam	Every 6 months
Coronary Heart Disease Screen	If applicable
Breast/Testicular Exam	Annually with physical
Mammogram	Annually after 40 y/o
Pap Smear/Pelvic Exam	Every 6 months (annually after 2 consecutive negative Pap Smears)
Discussion regarding HRT	Perimenopausal women
Digital Rectal Exam/PSA	Annually after 50 y/o, 45 y/o with risks
Anal Pap Smear	Consider annually with h/o anal receptive sex or HPV
Colon Cancer Screening	Annually after 50 y/o
Screening for Osteoporosis	Consider in all patients on long-term ARV especially in postmenopausal women and men with hypogonadism
STD/Hepatitis C Screen	Annually & as needed
Fasting Lipids	Annually after 35 y/o if not on ART, every 6 months on ART
PPD	Annually, every 6 months for high risk
Immunizations (Hepatitis A & B, pneumovax, Td, Influenza, varicella)	See CDC guidelines
Depression Screen	Annually & as needed
Diet & Exercise	Every 6 months
Advanced directives	Annually

Recommendations vary regarding screening for CHD. Many agree that screening should be considered for those with coronary risk factors (i.e., smoking, obesity, family history, men over 45, women over 55, diabetes, hypertension and hypercholesterolemia). Screening can be performed with resting ECG, exercise ECG, and nuclear imaging and stress echocardiography depending on patient risks and needs.

#### Immunization Table

Vaccine	Timing	Comments
Hepatitis A	Provide series one time	If HAV antibody negative
Hepatitis B	Provide series one time	If HBV antibody negative,, screening for
HBV should include HBV surface antibody, HBV core antibody, & HBV surface antigen (to screen for chronic infection)		
Influenza	Annually	
Pneumococcal	Every 5 years	
Tetanus	Every 10 years	Patients with CD4 counts < 200 should be
considered for revaccination when CD4 counts are > 200		

# HEALTH MAINTENANCE FLOW SHEET

Indicator	Date	Date	Date	Date	Date
Annual PE					
Medical History					
Case Management					
Mammogram					
Pap					
Fasting Lipids					
Dental Referral					
Oral Screen					
Treatment Education					
TB Screen					
Syphilis Testing					
Substance Use Assessment					
Mental Health Screen					

## HEALTH MAINTENANCE FLOW SHEET (CONTINUED)

Indicator	Date	Date	Date	Date	Date
Influenza					
Tetanus					
Pneumovax					
HEP B					
HEP A					
Ophthalmology					
Tobacco Counseling					
Medication Adherence					
Nutrition Data/Screen					
Risk Assessment					
Safer Sex/Family Planning					
Living Will					
Hospitalizations					

# DOCUMENTATION

- History of HIV-Positive status, including route of transmission, when first diagnosed
- Confirmation - Lab result or provider note.
- TB Test
- Pap smear
- Assessment for mental health and substance abuse.
- Risk Assessment – Documentation of discussions of safer sex at least quarterly; illicit drug use, domestic violence; support systems.
- Case Management

# CHART COMPONENTS

- Problem List
- Medication List
- Immunizations -- Influenza,  
Pneumovax, HEP A/B, Tetanus



# Customized Progress Notes



# PROGRESS NOTES

- Each visit – Height and Weight – Vital signs
- Adherence with treatment plans - doses missed
- CD4 & Viral Load every 3-4 months.
- Reduction of high risk behavior
- Annual syphilis serology

# Medication Adherence

## **Compliance:**

100% Compliant \_\_\_\_\_

Number of pills missed in the last week \_\_\_\_\_

\_\_\_\_\_ Client education given to improve compliance

# BOOSTING MEDICATION ADHERENCE

- Smart Phone Applications
  - HealthPrize
  - MediRemind
  - Pillboxie
- Remind clients when & how to take meds plus turn adherence into an interactive game – prizes/gift certificates

# Healthful Food a Key in Treatment



- HIV patients who have inadequate access to nutritious food are more likely to face hospitalizations and ER visits

# NUTRITION SCREEN

- Access to a variety of food – money to buy food and ability to cook
- How many meals are eaten every day?
- Amounts of:
  - PROTEIN - approx. 3 servings per day
  - DAIRY - 2 servings per day
  - BREADS & CEREALS - 4 servings per day
  - FRUITS & VEGETABLES - 3 servings per day

# SUPPORT SERVICES

- Grantee must ensure that health education and risk reduction services are provided to educate clients living with HIV about
  - HIV transmission
  - How to reduce the risk of HIV transmission.

# Patient Teaching

- 1) Reviewed disease process \_\_\_\_\_
- 2) Reviewed dietary intake \_\_\_\_\_
- 3) Reviewed med dosages &  
precautions \_\_\_\_\_
- 4) Reviewed safer sex \_\_\_\_\_





## Patient Outcomes

- \_\_\_\_\_ Patient knowledgeable of disease process & transmission.
- \_\_\_\_\_ Patient knowledgeable of medications and precautions.

